Substance Addiction (Compulsory Assessment and Treatment) Bill

Submission to the Health Committee

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Contact

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About the New Zealand Nurses Organisation

NZNO is the leading professional nursing association and union for nurses in Aotearoa New Zealand. NZNO represents over 47,000 nurses, midwives, students, kaimahi hauora and health workers on professional and employment related matters. NZNO is affiliated to the International Council of Nurses and the New Zealand Council of Trade Unions.

NZNO promotes and advocates for professional excellence in nursing by providing leadership, research and education to inspire and progress the profession of nursing. NZNO represents members on employment and industrial matters and negotiates collective employment agreements.

NZNO embraces te Tiriti o Waitangi and contributes to the improvement of the health status and outcomes of all peoples of Aotearoa New Zealand through influencing health, employment and social policy development enabling quality nursing care provision. NZNO's vision is *Freed to care, Proud to nurse*.

EXECUTIVE SUMMARY

1. The New Zealand Nurses Organisation (NZNO) welcomes the opportunity to comment on Substance Addiction (Compulsory Assessment and Treatment) Bill.

2. NZNO has consulted its members and staff in the preparation of this submission, in particular members working in substance addictions services, members of NZNO's Mental Health Nurses Section, College of Primary Health Care Nurses; te Rūnanga; and NZNO's legal, nursing, research and policy advisers.

3. NZNO **supports** the Bill which has been anticipated for some time and updates legislation in line with modern health practice.

4. We draw your attention to some perceived anomalies in the interpretation with regard to the various terms used for health practitioners.

5. We also take this opportunity to briefly raise some issues around the exclusion of voluntary commitment and considerations other than the safety of the person with a substance addiction. In particular, we suggest consideration should be given to providing more regulatory assessment and treatment options for pregnant women with a substance addiction in order to protect the child.

6. Notwithstanding the small number of people the Bill is likely to apply to, we submit that there is not sufficient capacity to accommodate even

the small predicted increase from 70- 200 people in inpatient facilities for alcohol and other drug addiction (AOD) treatment, and that it is likely that other services users will be adversely impacted.

7. We suggest the penalties for offences (cl110-114) are relatively low in comparison with other jurisdictions, such as the United Kingdom.

8. NZNO does not wish to make an oral submission.

DISCUSSION

General

9. NZNO welcomes and supports the Bill which simplifies and updates existing legislation to reflect modern thinking and practice.

10. We agree with the Bill's purpose, to protect persons mentally incapacitated by addiction, and support the principle of least restrictive practice and the guidance offered to practitioners in clause 12 *The principles applying to the exercise of powers over patients*.

11. There is general agreement that, even in severe cases, compulsory treatment for substance addiction is rarely effective in the long term; enforced rehabilitation is a gruelling and distressing process that may involve personal and physical restraint, force feeding, injections and medication which can be, "a damaging and ugly process" for both staff and the recipient, according to our nurses.

12. The very high threshold for compulsory treatment outlined by paragraphs a) b) and c) in clause 7 *Criteria for compulsory treatment* is warranted, in our opinion.

13. However, we question the inclusion of para d) *that appropriate treatment for the person is available*. In effect this is a potential "out-clause"; if no treatment is available the person does not suddenly become well and safe, they are still seriously compromised, and lack of available treatment" is not an appropriate criterion for this protection not being offered.

14. We note that the Bill is less prescriptive than the Mental Health Act 1992 which, for instance, is more clearly weighted towards medication-related treatment rather than the array of therapies now considered appropriate. Similarly there is a degree of flexibility around eg determining whether voluntary treatment is likely to be effective, which are appropriately left to other regulatory instruments.

15. Clause 8 gives the meaning of substance addiction but does not adequately address the transitory nature of symptomology where substance addiction is concerned. We suggest the clause could be

modified to more effectively address the presence of mental illness as well as substance addiction.

16. Clause 56 entitles every patient to consult a health professional who specialises in addiction medicine and is approved under clause 95 for a second opinion. However, it does not specify a timeframe for this to occur, which we would recommend. Similarly with clause 57 *the right to legal Advice*.

17. We suggest it is important to have provision for urgent review of a patient's status where the patient and/or other specified persons apply to the court on the grounds that the criteria for a compulsory treatment order are not met. We also suggest that potential costs and other barriers should be considered in this regard. For instance, the Court could appoint a person to support the family, rather than just informing them. Families in these situations are often confused and vulnerable.

18. Finally we suggest that suggest the penalties for serious offences (cl110-114) which include intentional neglect or ill treatment of patients, obstruction, and falsifying certificates are relatively low in comparison with other jurisdictions. The United Kingdom's Mental Capacity Act 2005, for example imposes substantial fines and/or up to five years imprisonment. We recommend the penalties are reviewed.

Reducing prenatal harm

19. We note that both the Law Commission and the Ministry of Health recommended that the Bill exclusively focus on protecting the *health* of the person who's mentally impaired by substance addiction, rather than protecting others around them. We support substance addiction being treated as a health rather than law and order issue, though at times they coincide.

20. However, in view of the considerable attention given to the development and implementation of the Vulnerable Children's Act 2014 which is focused on identifying and preventing child abuse, we suggest that there is an urgent need for consideration of the special circumstances of AOD addicted pregnant women.

21. Nurses are particularly concerned at the number of pregnant women addicted to methamphetamine ("P") who need assessment and treatment prior to birthing, and whom they need to alert Child Youth and Family Services to.

22. However, Fetal Alcohol Spectrum Disorder (FASD) is the most prevalent, recognised and rapidly increasing preventable AOD problem with far reaching and lifelong health, social, and economic consequences.

23. As we noted in our submission to the Ministry on their discussion document *Taking Action on Fetal Alcohol Spectrum Disorder* earlier this year, several countries have child welfare laws to address prenatal drug exposure (treating the issue as a matter of civil rather than criminal law). Such laws vary considerably as this is a very complex area, but we believe it warrants some attention in a document focused on preventable prenatal harm from alcohol.

24. At present we have no concrete policy suggestions, but suggest there is a need for urgent review and at least some provision for pregnant women addicted to harmful substances to be able to commit themselves voluntarily, or for compulsory assessment and offer of treatment, if not actually mandated treatment.

25. It may be appropriate and timely to convene a forum of involved health practitioners with addiction experience to consider this.

Reference to health practitioners

26. There is some ambiguity arising from the various ways health practitioners are referred to in the Bill, which reflects the Mental Health Act 1992 rather than modern practice.

27. For example, in the Interpretation an *approved specialist* means a *health professional* designated under section 95, and a *health professional* means a person who has one or more of the following:

    - a medical practitioner, psychologist or nurse registered under authority of section 114(a) of the Health Practitioners Competence Assurance Act 2003 (HPCAA);

    - a practitioner with expertise in treating people with severe substance addiction;

    - a registered social worker designated by the Director of Addiction Services (DAS) or Director of Area Addiction Services (DAAS).

28. *Health professional* is not a term found in the HPCAA which provides the legislative framework for the regulation of health practitioners.

29. A separate meaning is given for *medical practitioner* i.e. has the same meaning as in section 5(1) 1 of the HPCAA, but not for other regulated health practitioners; and while *health practitioners* are referred to elsewhere, eg cl 95, the term is not included in the interpretation (cl 4).

30. The Bill also refers to and defines *responsible clinician* - means *approved specialist* assigned under section 28.

31. In this context ie the meaning of approved specialist and responsible clinician, we note that a social worker is not a clinician, and that “a practitioner with expertise in treating people with severe substance addiction” needs clarification as this could describe a support worker or peer case worker, who are also not clinicians.

32. NZNO recommends a more consistent approach that would also be in line with the recommendations in the Committee’s report on the Health Practitioners (Statutory Reference to Medical Practitioners) Amendment Bill “to facilitate innovative and efficient practice”. Eg We recommend that you consider replacing *health professional* with *health practitioner* with *health practitioner* has the same meaning as in s5(1) 1 of the HPCAA”.

33. Broad high level legislation, which is underpinned by robust processes for detailing practitioner responsibilities and practice, avoids potential barriers to modern practice that reference to specific practitioner roles risks.

34. For instance in relation to Part 2 *Assessment and treatment of persons suffering from severe substance addiction*, several clauses refer only to medical practitioners, though nurse practitioners (and other clinicians) may also perform these functions.

35. With regard to Information that must be given to patients and others, cl 26(2)(f) states that information must be given to “the medical practitioner who usually attends the patient”; in some instances the practitioner who usually attends the patient is a nurse practitioner or a credentialed Drug and Alcohol Nurse specialist.

36. It is essential that highly experienced and qualified practitioners in this specialist and demanding area of substance addiction are fully utilised rather than excluded.

Implementation

37. While the numbers involved are small, members are concerned that existing services would struggle to meet the demand and reducing the inpatient facilities is likely to adversely affect and delay treatment for other people with AOD addictions.

38. As one nurse graphically describes:

> There is no way the public health system could currently carry this out with available funding and resources. Currently many DHBs lack dedicated detox facilities and detoxing for eight weeks in small hospital's medical wards is simply unfeasible because of the strain it would place on the medical facilities and personnel, and the inability of medical wards to prevent people from breaching any leave conditions.

> Placing people in mental health wards would further reduce already limited beds and is medically inappropriate for a complicated detox. Relocation to appropriate facilities in another DHB raises the logistical nightmare of asking small town police to assist and, even more importantly, separates the person from any support in their community, decreasing their chance of a successful long term recovery. RN

39. Adequate resourcing is clearly required to prevent the 'catch 22' situation whereby very limited services are prioritised for people who are unlikely to recover while those motivated and in need of treatment are unable to access services which would minimise harm and potentially lead to recovery.

40. Access to appropriately qualified and trained staff is likely to be a significant barrier to providing community-based services for timely and accessible treatment, particularly for rural areas.

41. However, with sufficient support, there will also be opportunities to make the significant changes needed to improve health outcomes through eg restructuring existing environments; and/or building new ones specifically designed to both detain and be therapeutic.

42. There will be decisions around the population mix in these facilities e.g. therapeutic communities with both voluntary and compulsory clients in the same groups. In this regard we note the Maori approach to care includes the wider family/ whanau in comparison to the views of the patient's principal caregiver, welfare guardian, and nominated person.

CONCLUSION

43. In conclusion NZNO **recommends** that you:

- **Note** our support for the Bill;
- **Note** our recommendations with regard to clauses 7, 8 and 56;
- **Align** references to health practitioners with the HPCAA rather than the Mental health Act eg by replacing *health professional* with *health practitioner* with *health practitioner* has the same meaning as in s5(1) 1 of the HPCAA";
- **Agree** that the Bill will only be effective if appropriate resources for both compulsory and voluntary treatment are made available;
- **Agree** that, in order to reduce lifelong preventable harm to vulnerable children, some provision for pregnant women addicted to harmful substances is urgently required ;

- **Consider** recommending an urgent review of child welfare laws to address prenatal drug exposure (treating the issue as a matter of civil rather than criminal law); and
- **Review** the penalties for offences outlined in (cl110-114).

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